ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

GASTROENTEROLOGY ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address:

Phone: Alternate Phone:

Height: Weight: Allergies: Allergy to latex? ☐ Yes ☐ No

DIAGNOSIS

Date of diagnosis: _____

Crohn's Disease: ☐ K50.0___ (Of Small Intestine) ☐ K50.1___ (Of Large Intestine)
☐ K50.8___ (Crohn's Disease of Both Intestines) ☐ K50.9___ (Crohn's Disease, Unspecified)

Ulcerative Colitis: ☐ K51.0___ (Ulcerative Pancolitis) ☐ K51.2___ (Ulcerative Proctitis) ☐ K51.3___ (Ulcerative Rectosigmoiditis)
☐ K51.5___ (Left Sided Colitis) ☐ K51.8___ (Other Ulcerative Colitis) ☐ K51.9___ (Ulcerative Colitis, unspecified)

IBS with diarrhea ☐ K58.0 **IBS with constipation** ☐ K58.1 **Drug-induced constipation** ☐ K59.03 **Chronic idiopathic constipation** ☐ K59.04

Hepatic Encephalopathy ☐ K72._____ **Other** ☐ _____ (ICD-10 : _____)

CLINICAL INFORMATION

Date of TB test: _____ **Results:** ☐ negative ☐ pending
Treatment History: ☐ New start ☐ Restart ☐ Continuing therapy ☐ Drug change
Failed Therapies: ☐ Corticosteroids ☐ 6-MP ☐ 5-ASA ☐ Sulfasalazine ☐ Linzess
☐ Fiber ☐ Stimulants ☐ Laxative ☐ Osmotic laxative

Current therapy: _____
Stop before starting new therapy? ☐ Yes ☐ No
Withhold for how long before starting: _____

DRUG		DIRECTIONS	QTY	REFILLS
☐ **AMITIZA**	☐ 8 mcg **(IBS-C)** ☐ 24 mcg **(CIC)**	☐ Take 1 capsule PO twice daily		
☐ **CIMZIA**	☐ 200 mg **vial** ☐ 200 mg **PFS**	☐ **Loading dose:** Inject 400 mg (two 200 mg injections) SQ on weeks 0, 2, and 4, then maintenance **Maintenance dose:** ☐ 400 mg (two 200 mg injections) SQ every 4 weeks ☐ 200 mg SQ every 2 weeks	6	0
☐ **ENTYVIO**	300 mg vial	☐ **Loading dose:** Infuse 300 mg at weeks 0, 2, and 6, then once every 8 weeks ☐ **Maintenance dose:** Infuse 300 mg every 8 weeks	3	0
☐ **HUMIRA** ☐ **HUMIRA Citrate Free** (lower volume)	☐ 20 mg **PFS (<40 kg)** ☐ 40 mg **PFS** ☐ 40 mg **Pen**	**Initial dose (choose one):** ☐ Inject 80 mg SQ on day one, 40 mg on day 15, then begin maintenance ☐ Inject 160 mg SQ on day one, 80 mg on day 15, then begin maintenance ☐ Inject 80 mg SQ on day 1, day 2, and day 15, then begin maintenance **Maintenance dose:** ☐ Inject 20 mg SQ every 2 weeks ☐ Inject 40 mg SQ every 2 weeks ☐ Inject 40 mg SQ weekly		0
☐ **LINZESS**	☐ 72 mcg **(CIC)** ☐ 145 mcg **(CIC)** ☐ 290 mcg **(IBS-C)**	☐ Take 1 capsule PO once daily at least 30 minutes prior to first meal of the day		
☐ **REMICADE**	100 mg vial	☐ **Loading dose:** Infuse _____mg IV on: week 0, week 2, and week 6, then maintenance ☐ **Maintenance dose:** Infuse _____mg IV every ____weeks		0
☐ **RELISTOR**	☐ 8 mg **PFS** ☐ 12 mg **PFS** ☐ 150 mg **tablet**	☐ Inject one PFS SQ once daily ☐ Take three tablets (450 mg) PO once daily in the morning		
☐ **SIMPONI**	☐ 100 mg **PFS** ☐ 100 mg **Smartject pen**	☐ **Loading dose:** Inject 200 mg SQ at week 0, 100 mg at week 2, then begin maintenance at week 6 ☐ **Maintenance dose:** Inject 100 mg SQ every 4 weeks	3	0
☐ **STELARA**	☐ 130 mg **vial** ☐ 45 mg **PFS** ☐ 90 mg **PFS**	☐ **Initial dose:** Infuse _____mg IV as single dose, then begin maintenance dose 8 weeks later ☐ **Maintenance dose:** Inject one PFS SQ every 8 weeks		
☐ **TRULANCE**	3 mg tablets	Take 1 tablet (3 mg) PO once daily		
☐ **UCERIS**	☐ 9 mg **XR tablet** ☐ 2 mg **rectal foam**	☐ Take 1 tablet (9 mg) by mouth once daily in the morning for up to 8 weeks ☐ Apply 1 metered dose twice daily rectally for 2 weeks, then 1 dose every evening for 4 weeks	56	0
☐ **XELJANZ**	☐ 5 mg tablet ☐ 10 mg tablet	☐ Take 1 tablet PO twice daily ☐ Alternate dosing:		
☐ **XIFAXAN**	550 mg tablet	☐ **Hepatic encephalopathy:** Take 1 tablet (550 mg) PO twice daily ☐ **IBS-D:** Take 1 tablet (550 mg) PO three times daily for 14 days		
☐ **OTHER:**				

☐ Patient is ready to start treatment, contact patient for delivery ☐ Ship all orders to office ☐ Ship first order to office, subsequent orders to patient

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.